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Q. Do you have an understanding as to whether -- let's focus on drugs administered in physicians' offices. Do you have an understanding as to whether the amount -- how the amount that a physician would submit for reimbursement pursuant to an indemnity plan would be calculated or listed?
MR. COCO: Objection.
A. Not specifically, no.
Q. Do you have an understanding as to whether or not members submit their actual charges for reimbursement when seeking reimbursement pursuant to an indemnity plan?
MR. COCO: Objection.
A. Members?
Q. I'm sorry, providers.
MR. COCO: Objection.
A. Not specifically for indemnity plans, no. I'm not sure what the -- no, not specifically for indemnity plans.
Q. Now, does BC/BS of Massachusetts still have indemnity plans?

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A. Yes.
Q. Is it one plan or more than one?
A. I suspect more than one plan.
Q. Do you know who is knowledgeable regarding those plans?
MR. COCO: Objection.
A. Not offhand, no, I don't.
Q. Do you have an understanding as to how many members currently receive health from BC/BS of Massachusetts pursuant to an indemnity plan?
A. I think roughly somewhere around 200,000.
Q. And what is the total number of individuals who receive coverage through BC/BS of Massachusetts?
A. Close to 3 million.
Q. Do you know how the proportion receiving coverage through indemnity plans has changed over time?
A. It has diminished over time.
Q. Do you have a sense as to how fast or slow the rate of diminishment has been?

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A. Not really.
Q. Now we've talked about employees at BC/BS of Massachusetts who are MDs.
A. Uh-huh.
Q. I would like to ask you now about employees of the company who have previously been employed by drug manufacturers. Do you know of any individuals who at some point have worked for drug manufacturers?
A. Not offhand.
Q. Now, what is the Blue Cross/Blue Shield Association?
A. It's a business association of Blue Cross/Blue Shield plans across the United States.
Q. What is the relationship between the different Blues plans throughout the country?
A. I believe we're sort of a loose affiliation. And I don't mean that in a technical sense. I mean, I don't know what the business relationship is, but the Blues plans are independent subsidiaries, so they're not all owned by the same business entity.

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Q. Does Blue Cross/Blue Shield of Massachusetts have communications with other Blues plans around the country?
MR. COCO: Objection.
A. I believe so, but I don't know for sure.
Q. Do you know what sorts of issues are subject to communications between the different Blues plans?
MR. COCO: Objection.
A. They have, like, annual meetings where they talk about, you know, the best in Blues. They talk about what, you know, people are doing in medical management, disease management, et cetera.
Q. To your knowledge, does Blue Cross/Blue Shield of Massachusetts receive any reports from the BC/BS Association?
A. I don't know for sure.
Q. To your knowledge, does BC/BS of Massachusetts process claims for any other Blues entities?
A. Yes, I believe we do.
Q. In what circumstances does BC/BS of

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Massachusetts process claims for another Blues plan?
A. Something called Blue Card.
Q. Okay. What is the Blue Card?
A. Boy, you ask good questions. The Blue Card, it's a program where people can have -- you can -- let's say you work for an employer whose main corporate headquarters is in California and you buy Blue Cross/Blue Shield of California for your employees, but you have an office in Massachusetts, and those people would have that type of insurance, healthcare insurance from Blue Cross/Blue Shield of California, but they would be living in Massachusetts, and they would be seeing Massachusetts providers. And so in those circumstances we would process those claims for Blue Cross/Blue Shield of California.
Q. Now, taking -- sticking with your example, in that situation how would the rate at which the Massachusetts physicians are reimbursed be determined?
MR. COCO: Objection.

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A. I'm not 100 percent sure, but I believe it's -- they use our contracted rates, because they have to use our networks.
Q. Okay. So in the situation you've described the entity in California that's contracting with BC/BS of California will get access to the BC/BS of Massachusetts network for its members who are in Massachusetts to use, but they will then be subject to the reimbursement rates that BC/BS of Massachusetts has negotiated with its network?
A. I believe so.
MR. COCO: Objection.
Q. Now, do you have an understanding as to whether the rates that BC/BS of Massachusetts negotiates are different or the same as those of other Blues plans?
MR. COCO: Objection.
A. Don't know.
Q. Now, we spoke about your time at the Braintree site, Medical East. Do you have an understanding as to how that staff model HMO was

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structured?
A. Meaning?
Q. Well, in terms of the organization was there one side, were there many sides, how did they come together, what was the length of BC/BS, general organization. There were many sites that were owned by Blue Cross/ Blue Shield of Massachusetts? Do you know how many sites there were?
A. I can't remember anymore. I think I knew at one time.
Q. Now, do you have an understanding as to how the organization was structured in terms of personnel? Was there a particular group or person in charge of the staff model HMO?
A. There was a chief administrator I believe at each site, but I'm not really sure what the super organization was about that.
Q. Do you know whether or not the chief administrators at each site reported to a specific person or a committee?
A. That, I don't know.

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Q. Do you know who the chief administrator was at the Braintree site when you worked there?
A. Maureen Coneys.
Q. And how do you spell her last name?
A. C-O-N-E-Y-S.
Q. Is Ms. Coneys still with BC/BS of Massachusetts?
A. Yes, she is.
Q. What is her current title?
A. Good question.
Q. Is she on the --
A. She's on the org. chart here, guys.
Q. Okay.
A. Hang on. I saw her name somewhere in here.
(Witness reviews document.)
A. Woops, there it is on 137.
Q. So this is the page entitled "Healthcare Services Organization"?
A. Correct.
Q. And she is the healthcare quality and cost senior vice president?

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A. Correct.
Q. Okay. What does the health care quality and cost department do?
A. I believe responsibilities cover the clinical service area that does utilization management, disease management, case management and she probably had some other responsibilities of which I'm not aware of.
Q. Now, how long was Ms. Coneys the chief administrator at the Braintree site?
A. That, I don't know.
Q. No. How long were you aware of her being in that position?
A. I believe she was in that position for the entire time that I was there.
Q. Okay. Which was in '92?
A. '89 to sometime in -- like through '94. I believe she was. I could be wrong about that.
Q. Now, do you have an understanding as to how the staff model HMO or the Braintree site went about acquiring drugs?
A. No.

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Q. Do you know who at the staff model HMO on the Braintree site would have knowledge of that issue?
A. No, I mean, not offhand. Maureen might have, but I mean, I would assume somebody in administration did, but I don't know particularly anybody.
Q. But Ms. Coneys was the person in charge of that particular site; is that correct?
A. Correct.
Q. How many people worked at that site when you were there?
A. I don't really know. I would guess 40, 50.
Q. Are you including medical professionals in that?
A. Yes.
Q. Okay. How many people who worked there when you take out the medical professionals, the doctors, the nurses?
A. All -- you mean, like nurses and nursing assistants and things like that?

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Q. I'm trying to find out how many people were working on the administrative or corporate side.
A. Maybe a handful. There could have been more, but I would say maybe a small number, I think.
Q. Less than five?
A. Yeah. I don't know for sure.
Q. Of whom Ms. Coneys was one?
A. Yes.
Q. And she was the person in charge?
A. Yes.
Q. Now, in that time period, early to mid-'90s, do you know what proportion of BC/BS of Massachusetts membership was serviced through the staff model?
A. If you knew, I don't remember.
Q. Are you familiar with Gary Kerr?
A. No.
Q. No? How about a Mark Rubino?
A. Doesn't ring a bell.
Q. Now, shifting gears, who are the BC/BS

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of Massachusetts main competitors in the market where it operates?
A. Harvard Pilgrim Health plan, Tufts and --
Q. Any others?
A. Fallon Health Plan. Those are the big ones, Health New England.
Q. I'm sorry, which one?
A. Health New England.
Q. How big is Health New England?
A. Not very big.
Q. Are there smaller --
A. It's the western part of the state. And Fallon Health Plan is the central part of the state. So the big ones are Harvard Pilgrim and Tufts Community Health Plan, and then I guess Neighborhood Health.
Q. Okay. Does BC/BS of Massachusetts operate only in Massachusetts, as the name would imply?
A. Yes. To the best of my knowledge, yeah.
Q. Does it cover the entire state?

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A. Yes, to the best of my knowledge.
Q. Now, would you consider Massachusetts to be a competitive market in terms of health insurance products?
MR. COCO: Objection.
A. What do you mean by "competitive"?
Q. Well, is it a market where health insurers, Tufts, Fallon, Neighborhood, BC/BS of Massachusetts, compete vigorously for clients?
MR. COCO: Objection.
THE WITNESS: You need caffeine.
A. In my perspective, yes. I think we are competitive.
Q. Now, what sort of entities are the clients who these different plans are competing for?
A. Business, business entities.
Q. So one type of entity would be everything from a law firm to a GE, any corporate entity that employs individuals, right?
A. Correct.
Q. And those individuals would then, if

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BC/BS gets the employer as a client, get their coverage through BC/BS of Massachusetts?
A. That's correct.
Q. Okay. Are other types of clients health and welfare funds?
A. What do you mean, "health and welfare"?
Q. Are you familiar with the term "health and welfare"?
A. Not really.
Q. What about unions; are there any unions that are clients?
A. Could be, I guess.
Q. Now, is it fair to say that the majority of the clients with whom you're personally familiar are the employers or employment groups?
A. I guess so. I don't have any real direct contact usually with employers or accounts. I'm usually -- my direct contact was provider community.
Q. What sort of -- well, who does have the direct contact with clients?
MR. COCO: Objection.

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Q. What department or individual?
A. Sales and marketing department, I would say, probably has the most direct.
Q. And who's currently in charge of that department?
A. Let me look. Okay. So at least Steve Booma.
Q. Do you know how long he's been in charge of sales?
A. No, not exactly.
Q. Now, do you know what factors clients consider when choosing between the different health insurance in the Massachusetts area?
MR. COCO: Objection.
A. Not directly. I mean, I think -- we hope quality and price, and that's what I think, but I don't know too much more about it than that.
Q. Yeah. Well, sticking at that level of generality, when you say "price," what are you referring to?
A. Health --
MR. COCO: Objection.

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A. Healthcare premium.
Q. Now, what sort of factors go in to determination of what the premium is that BC/BS of Massachusetts would charge to its clients?
MR. COCO: Objection.
A. It's really complex, and I really don't know all the -- how all that is determined. It has to -- you know, it's a big part of our company is actuary and pricing. So I can't tell you all the elements that they look at.
Q. Okay. Certainly we can agree that one of the elements that will go into determining premium rates are the costs to BC/BS of Massachusetts of reimbursing providers?
MR. COCO: Objection.
A. I think you could say claims cost, yes. If you want to say claims cost, yes.
Q. Sure.
A. I would think that that would be one of the things.
Q. And by claims costs I think you're referring to, -- I think we're talking about the

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same thing which is the amount that BC/BS pays in reimbursing for claims submitted by providers?
MR. COCO: Objection.
A. It's medical -- the payments we pay for medical services rendered, yes.
Q. Okay. And that is related to the area in which you worked as the medical director, right?
MR. COCO: Objection.
A. I don't understand that.
Q. Okay. Well, part of your job responsibilities involves liaising with the provider community; is that correct?
A. That is correct.
Q. So when providers have complaints -- have complaints about their reimbursement or the amount they're being reimbursed, one of the people they could come to talk to about that is you, right?
MR. COCO: Objection.
A. Correct.
Q. Okay. So in that capacity or in that

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role you are involved in liaising with providers in relation to reimbursement issues?
MR. COCO: Objection.
A. On that level, yes.
Q. Okay. And those reimbursement issues or those amounts that are paid in relation to those claims are one of the many factors that then go into the process of premium set; would that be a fair statement?
MR. COCO: Objection.
A. You know, I don't directly know what goes into premium setting, but it would be my understanding that medical claim costs would factor into that.
Q. Now, what does BC/BS of Massachusetts do towards assessing or analyzing the amounts that it is paying providers in relation to services and drugs that they provide?
A. I don't know.
MR. COCO: Objection.
Q. What department would deal with that issue?

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A. I would assume the actuary department would.
Q. Approximate and who's in charge of the actuary department?
A. Rina Vertes.
Q. Well, in your role in liaising with providers when reimbursement issues do come up, what are the interests that BC/BS of Massachusetts looks to maintain when dealing with providers on those issues?
A. Can you restate that?
Q. Sure. When a provider makes a complaint, let's say a provider comes in and says, "I'm not being reimbursed enough in relation to this service or this drug," what are some of the considerations that you look to in deciding how to respond to that provider?
MR. COCO: Objection.
A. You know, I don't have the responsibility for setting payment policy. My role really is to respectfully listen, to gather information and to forward it on. I may

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participate in a discussion, but I don't have the ability to change or set or alter payment policy personally.
Q. Are you responsible for responding to the physician in response to a communication you've received from them?
MR. COCO: Objection.
A. A lot of times, yes.
Q. So what you're saying is you're not the one that actually sets the policy, but you are the conduit through which complaints are received and then responses are given?
A. A lot of the times, yes.
Q. Now, in terms of the responses that you do provide on those issues, do you have an understanding as to what some of the considerations are that factor into responses?
MR. COCO: Objection.
A. That's pretty broad. What do you mean by that?
Q. Well, do you recall any specific instances where you received complaints from

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providers about the amount of reimbursement that they provide?
A. Sometimes yes, okay. An example could be we would hear from a surgeon who says that "I think that this surgery was more complex and the reimbursement for the surgery -- you know, I think I should have gotten paid more for that."
Q. Okay.
A. And that would be the kind of issue that might come to me and then I might forward to another area of the company to look at that and see if that was reasonable or not.
Q. And what is the range of responses that you might receive to a complaint of that sort?
MR. COCO: Objection.
A. You mean from the people I talk to?
Q. Right.
A. Our fee schedules are pretty standardized, so we really don't customize or deviate from them in general. There is always individual consideration, let's say, on the surgeries. There is a department that would look

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at the operative notes and say that something unusual happened here or something that was beyond normal, and I believe that area has the ability to say to it adjusts -- like the surgery went on for extra long or there was -- complicated in some way that the quoting wasn't clear about elucidating, that that area could look at and it, say, okay, you know, the standard fee is X and maybe we'll give you a little bit more because it took 12 hours.
Q. So is there a department that gives individualized consideration to concerns or complaints of the type we've discussed?
A. In terms of like --
MR. COCO: Objection. Sorry.
THE WITNESS: Sorry.
A. In terms of like the surgery thing, sure, there is.
Q. Okay. What department is that?
A. That's individual consideration and provider services.
Q. How many people work in that department?

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A. That, I don't know.
Q. But that's -- if you received a complaint of that sort, you would forward it on to that department; is that correct?
A. Yes.
Q. And they would then look at it, assess it and respond through you to the physician?
A. Sometimes through me, and sometimes they directly respond to the physician.
Q. Now, would it be fair to say that BC/BS of Massachusetts by implementing this individualized assessment process is looking to give a fair hearing to any complaint that a provider may have?
MR. COCO: Objection.
A. I think a more accurate description would be that Blue Cross/Blue Shield of Massachusetts likes to listen to its providers and likes to be -- you know, understand what their concerns are, and we like to feel that they felt that they've been heard.
Q. But of course at the same time Blue

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Cross/ Blue Shield of Massachusetts also wants to make a decision that takes account of its own cost concerns and the amounts that it would be paying out in reimbursement?
MR. COCO: Objection.
A. I wouldn't say that as much as saying -- I would say that our fee schedules tend to be standardized. We really don't -- in terms of like the physician fee schedules, we don't negotiate with individual physicians, individual fee schedules. And so I think what you're hearing more is that we're willing to listen and in some cases, some sort of extraordinary situation we will make a slight adjustment. I think -- particularly I'm thinking of surgeries that might happen.
Q. Where the complaints are received of the type that we've been discussing, would it be fair to say that one consideration is whether or not the physician's claim has merit, whether or not it's fair enough that he should be entitled to more on account of the specific circumstances?

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MR. COCO: Objection.
A. You know, I don't know exactly what the -- since I don't do the considerations, I don't know exactly what people look at when they do them.
Q. Okay. How many people are involved in that individualized adjudication process?
A. That, I don't know exactly.
Q. But there is a department within the provider services that does that?
A. Correct.
Q. Does BC/BS of Massachusetts seek to -- well, withdraw that. In terms of the analysis that's performed on the variations that's made to reimbursement amounts in these individualized circumstances, do you know whether that's tracked or analyzed in any form?
A. I don't --
MR. COCO: Objection.
A. I don't know.
Q. If it were analyzed, would it be within that same provider services department?

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MR. COCO: Objection.
A. I don't know that, either.
Q. Okay. Other than the provider services department, are there any other individuals or departments who are involved in responding to any complaints that may be received from providers?
A. Well, provider services in area in general deals with complaints. There's the area, the physician review unit. It's not -- it would be more like an appeal, not a complaint. That's a different unit -- would maybe look at those and appeal on a determination or appeal on a medical policy, that area. So there's an individual consideration in medical policy. And then I say that, provider service. Provider relations representatives would probably -- they'd hear about current issues with the provider community. I think that pretty much covers it.
Q. So let me see if I understand the structure. If a provider has a complaint about reimbursement he's getting, he can contact his provider relations rep; that's one avenue open to

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him?
A. Correct.
MR. COCO: Objection.
Q. Or he can contact you as a medical director; that's another avenue open to him --
MR. COCO: Objection.
Q. -- is that correct?
A. Correct.
Q. The complaint will then be subject to a process of consideration and adjudication within the provider services department; is that correct?
MR. COCO: Objection.
A. It depends on what the complaint is, and it depends on how far it goes and I mean -- I don't mean to be vague, but there's a lot of things that people could complain about, so...
Q. Are there some complaint that is don't reach that stage?
A. It could be depending on what the complaint is. I mean, people can complain about a lot of different things, right? So it could be something that's not going to go to that stage for

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whatever reason.
Q. Okay. Do you ever make the decision yourself as to not passing on a complaint any further?
A. Generally I pass on pretty much everything I get so that I can -- since I'm not the decision-maker in that capacity, I -- yeah, I pass it on.
Q. And this process that we've described -- well, withdraw that.
And after an initial decision is made by the provider services department when it does reach them, there's then also an appeals process that you've described; is that correct?
MR. COCO: Objection.
A. If it's -- I mean, we're kind of mixing apples and oranges here. There's a lot of different things. If you were going to appeal a medical policy.
Q. Well, let me focus the question again.
A. Okay.
Q. Let's focus the physician complaining

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about the amount of reimbursement he's received in relation to a service performed or a drug administered.
MR. COCO: Objection.
A. If it's a complaint that -- it was a surgical issue where you receive an individual consideration. If it's a complaint about the fee schedule, that isn't necessarily going to -- there is a committee that looks at physician payment review that could, you know, look at that complaint and sort of in a broad class and should we change our payment policy, that could happen.
But it wouldn't be an individual -- that committee could make a determination, but generally they don't make it on an individual basis. The individual consideration is pretty much reserved for, let's say, the nebulous surgery area, but in general, our fee schedule is as stated and, you know, we don't negotiate with individual physicians the fee schedule.
Q. Now, when you say you don't negotiate the fee schedule, are you referring to fee

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schedules dealing with drugs or administered to patients in office or fee schedules pertaining to services or both?
MR. COCO: Objection.
A. To the best of my knowledge, both.
Q. Now, how long has BC/BS of Massachusetts have a policy whereby it does not negotiate either the drug or the service fee schedule?
MR. COCO: Objection.
A. I don't know.
Q. How long were you aware of that policy having been in place?
MR. COCO: Objection.
A. Since I started my current role in the 2000s.
Q. Is there one master fee schedule that covers all providers with relation to drugs and services?
MR. COCO: Objection.
A. You mean -- I mean, there are all kinds of providers. You mean like a physician payment schedule; is that what you mean, or --

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Q. When I say "providers" I'm referring to physicians.
A. Okay. Physicians. There is a physician fee schedule, and that something that -- yes, there is a physician fee schedule.
Q. And that schedule covers both drugs and services?
MR. COCO: Objection.
A. You know, I don't know that. It covers services.
Q. Do you know whether there is only one physician fee schedule or is there more than one?
MR. COCO: Objection.
A. There is a physician fee schedule. Sometimes on contractual negotiations with certain groups there may be multipliers applied to that fee schedule for additional performance like pay for performance, risk contracts, but there is a basic fee schedule.
Q. Let's talk about that, multipliers that are multiplied for payer performance contracts. Are there any circumstances in which there's

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variation from the master fee schedule other than what you've just referred to, multipliers or payment performance contracts?
MR. COCO: Objection.
A. Not that I can think of offhand.
Q. Now, what are pay for performance contracts?
A. Certain services are outcomes that we think as a business entity are valuable for our members like percentage of women getting mammograms or pap tests, percentage of diabetics who are receiving the needed care they're supposed to have against industry standards, those kinds of activities. There might be a contract with a group that if they meet certain targets, they might be eligible for additional funding.
Q. What sort of targets are you talking about?
A. Well, a mammography, like, let's say a mammography rate. You know, if you have -- if you get 90 percent of your women -- if the network rate is 85 and you would get as a group 90 percent

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of your women to have mammograms, then there would be additional monies paid for you helping them to achieve that preventive target.
Q. And is -- okay. Other than incentives for attaining certain levels of preventative care, are there other actions that lead to a multiplier being applied?
MR. COCO: Objection.
A. Not that I'm aware of offhand, no.
Q. Okay. So all of the multipliers that you are aware of apply only to cases where physician practices reach targets in relation to preventative care?
A. It's not physician practices, it's larger. It's like delivery systems. It would be like a -- it wouldn't be like just a large physician practice. It would be like an IPA. And could they have other targets besides quality targets? Sometimes there's efficiency targets, but it's a large group. It's a large group, usually large group contracting like that or large entity contracting.

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Q. Do any of those -- are those pay for performance contracts offered to any entity in the marketplace that chooses to enter one?
MR. COCO: Objection.
A. You know, I don't know.
Q. Is that something that the provider contracting department would know more about?
A. Yes.
Q. Do you deal at all with the actual physical contracts between BC/BS of Massachusetts and providers?
A. Not really.
Q. Do you have any role in the drafting or signing of those contracts?
A. Sometimes I get involved in the negotiation of clinical elements like we talked about quality targets. I would be involved in the negotiation of what that target would become, but that's the extent of my involvement. Something that would be related to clinical piece.
Q. Do you see contracts after they're actually signed and entered into?

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A. Usually not.
Q. Now, what is your understanding of the methodology that is applied to determine the amounts that are set and the fee schedule in relation to drugs administered in office?
MR. COCO: Objection.
A. I'm not quite sure what you mean by that.
Q. Sure. Part of the fee schedules covers drugs that are administered by physicians to their patients and in their offices, right?
A. I guess --
MR. COCO: Objection.
A. You know, I don't think it's -- I'm not sure there's a separate fee schedule for that. I think that's just a payment policy related to that.
Q. Okay. What is the payment policy that you're aware of?
A. The payment policy for a physician that -- the drug administration physicians' office is AWP minus 5 percent, is what I'm aware of.

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Q. Are you aware that there are also other methodologies that BC/BS of Massachusetts utilizes?
MR. COCO: Objection.
A. The only thing that I'm aware of -- no, I guess that would be the same methodology. No, I think that's the only one I'm aware of.
Q. Are you aware of any capitation arrangements between Blue Cross/Blue Shield of Massachusetts and physician practices?
A. In terms of that kind of -- you mean in terms of physician -- drugs in the physicians' offices?
Q. I'm referring to a capitation arrangement that includes drugs.
A. You know, I'm aware of outpatient pharmacy drugs. I'm not aware that capitation -- they're negotiated -- I'm not familiar with physician office drugs.
Q. Are you familiar with a physician practice called Riverbend?
A. Yes.

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Q. Do you have an understanding as to what reimbursement methodologies exist between Blue Cross/Blue Shield of Massachusetts and Riverbend?
A. Not real clear right now because I think it's in transition.
Q. Do you know what it's moving towards or what it's coming from?
A. It was, I believe, a capitated arrangement and I believe it's moving towards a fee for service arrangement.
Q. Are you aware that a -- did you review any deposition transcripts in preparation for your deposition today?
A. No.
Q. Are you aware that a previous witness has testified that the Riverbend arrangement was capitated, including drugs administered in physicians' offices?
MR. COCO: Objection.
A. No, I'm not aware of that.
Q. Do you have any understanding as to why the Riverbend arrangement was capitated or was

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treated differently from other physician practices?
A. Not really. You mean, why they accepted a capitated arrangement versus a fee for service before or what --
Q. Why there was such an arrangement or why BC/BS of Massachusetts agreed to a certain arrangement with this practice versus others?
MR. COCO: Objection.
A. No, I don't.
Q. Did you have an understanding as to why Riverbend is now being moved to a fee for service methodology?
A. Not directly, no.
Q. Does Riverbend fall within the region that you're responsible for?
A. That's correct.
Q. Are you involved at all in the process of moving them from their capitated arrangement to a fee for service arrangement?
A. Extremely peripherally.
Q. Who is involved in that process more

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directly?
A. You mean, in terms of like contracting or --
Q. In terms of, yeah, negotiating the contract and the transition to a different methodology.
MR. COCO: Objection.
A. Provider contracting.
Q. Is there a particular person in provider contracting responsible for the relationship with Riverbend?
A. I believe it's Steven Moorehead.
Q. Do you have any idea how much money BC/BS of Massachusetts spends every year in relation to reimbursing for drugs administered in physicians' offices?
A. No.
Q. Do you have an understanding as to whether it's in the thousands or the millions or the tens of millions?
A. Well, I think it's more than that.
Q. Okay. So it's fair to say something in

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the millions of dollars?
MR. COCO: Objection.
A. I would assume, but I don't know if it is for sure.
Q. Do you know whether or not BC/BS of Massachusetts takes any steps towards monitoring or analyzing its expenditure on physician-administered drugs?
MR. COCO: Objection.
A. I don't know directly of any steps.
Q. Are you aware of the fact that BC/BS of Massachusetts considered whether or not it should move to an ASP methodology in the 2004 and early 2005 time period?
A. I know that certain people talked about it.
Q. Well, there was in fact a committee tasked with looking at that issue, wasn't there?
A. That, I don't know.
Q. Were you one of the people involved in consideration of that issue?
A. Not in terms of -- I don't remember

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being on any committee looking at that.
Q. Do you recall seeing any of the analytical work that was generated as part of that project?
A. No, I don't.
Q. Now, does BC/BS of Massachusetts have a department or individuals who are tasked with keeping abreast of developments in the market in terms of coverage in the press or the issuance of reports from the government, testimony in Congress, things of that kind?
MR. COCO: Objection.
A. There is a group that -- well, I guess legislative affairs that looks at some things. I don't know what the breadth of their -- breadth of what they look at, but they, you know, look at some legislation, things like that.
Q. Is it your understanding that if there were to be a debate in Congress pertaining to health insurance, drugs, prices or if there were to be reported issues by the government pertaining to the same issues, is it your understanding that

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that department would be responsible for monitoring such proceedings?
MR. COCO: Objection.
A. I don't know because I don't really know what the breadth of their responsibilities are.
Q. Okay. Do you personally keep track of reports issued by the government or press coverage that's relevant to the areas in which you work?
A. Some of it.
Q. Do you keep abreast of legal developments such as filing of lawsuits pertaining to drug prices or drug reimbursement?
A. Usually not.
Q. Now, do you have an understanding as to what is at issue in the lawsuit in relation to which you are being deposed here today?
A. Sort of a real high level understanding.
Q. Do you understand that Blue Cross/Blue Shield of Massachusetts is a plaintiff in this case?
A. Yes, I do understand that.
Q. And you understand that Blue Cross/Blue

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Shield of Massachusetts is a named class representative and that this is a class action proceeding?
A. I've heard that.
Q. What is your understanding as to the allegation that Blue Cross/Blue Shield of Massachusetts is making in this case?
A. My understanding was that it had to do with what the AWP meant and what kinds of pricing considerations that physicians were actually receiving in regards to the AWP.
Q. Now, one part of it, of what you just described is you said you understand the allegation is about what AWP meant.
A. Yeah.
Q. Specifically what is your understanding as to what AWP was supposed to mean, what it did mean?
MR. COCO: Objection.
A. In my understanding -- I just -- I thought it was a price. I thought it was the average wholesale price. I thought it was a

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number.
Q. Now, when you say you thought it was an average wholesale price, what do you mean by that?
A. I mean, I thought it was a number -- just -- I thought it was a number, a number.
Q. Well, it is a number, isn't it?
A. I think so.
Q. You're aware that the average wholesale price is a number that's publicly published and available in price reporting services?
A. Yes. It's got to be a number that's available, because people use that for payment.
Q. Okay.
A. So there is a number that is available for a drug. It's called the AWP, and there's a number.
Q. Right. That's listed as the AWP?
A. Yes.
Q. So it certainly is a number?
A. Yes.
Q. My question is, what did you think that number was supposed to represent, if anything?

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A. What it said it was supposed to --
MR. COCO: Objection.
Q. So you thought the AWP is supposed to be an actual average of wholesale prices; is that correct?
A. Well, I actually didn't think about it a whole lot. I thought it was a number -- yeah, I guess I thought it was the wholesale price, the average wholesale price.
Q. So you understand it to be an actual average of the prices at which entities in the market could purchase drugs from wholesalers?
MR. COCO: Objection.
A. I didn't give it that much thought. I think I thought it was just -- you know, if you say that, I guess -- well, I just didn't give it that much thought. I thought it was a number. In my world it's a number that people pay a percentage of.
Q. Now, when you say it's a number that people pay a percentage of --
A. Yes.

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Q. -- you're referring to AWP's use as a reimbursement benchmark; is that correct?
A. Yes. Correct.
Q. In other words, health plans will reimburse at a percentage discount off AWP?
A. Well, Medicare did and we did too.
Q. Now, did BC/BS of Massachusetts reimburse both pharmacies and physicians at the same methodology or a different methodology?
A. I don't know.
MR. COCO: Objection.
Q. You only deal with physicians?
A. Correct.
Q. Okay. Now, how long has BC/BS of Massachusetts reimbursed physicians at 95 percent of AWP?
A. I don't know that.
Q. Would it be fair to say that since Medicare adopted 95 percent of AWP as its methodology?
MR. COCO: Objection.
A. I really don't know.

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Q. Well, that methodology was in place when you became aware of it in the 2000 time period?
A. Yes.
Q. Okay. Now, if you were aware that Blue Cross/Blue Shield of Massachusetts is reimbursing at 95 percent of AWP, how did you reconcile that with thinking that AWP was an actual average of wholesale prices to physicians; in other words, putting both of your understandings together did you assume that all physicians are being reimbursed below their acquisition cost?
MR. COCO: Objection.
A. I really didn't think about it very much. I think that it was the pricing methodology that we adopted that was what we had -- Medicare was doing, and, you know, it's just a pricing methodology. I didn't give it a lot of thought.
Q. Well, let's think about it now. Can we agree that the natural implication of the positions that you've described would be, if true, that all physicians were being reimbursed below their cost?

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MR. COCO: Objection.
A. No, that doesn't make sense because if it was an average wholesale price, there would be people above and below, right?
Q. Fair enough. So the natural implication of your position is that there would be a segment of providers who were being reimbursed below their cost, correct?
MR. COCO: Objection.
A. But I really didn't think about it. I mean, to be fair, you're asking me to think about it now --
Q. Right.
A. -- but it's a pricing methodology. And I didn't think about what the actual acquisition cost was.
Q. That's fair. I understand that you didn't think about it at the time.
A. Yeah.
Q. But I'm asking you the question right now.
A. Yeah, yeah.

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Q. Is it fair to say that if the natural implication of your position would be, if true, that all physicians were being reimbursed at a rate that was below the average of their acquisition costs for drugs?
MR. COCO: I'm going to object to this whole line of questioning. The witness is here as a fact witness. You are entitled to probe her knowledge about facts. Asking her to sit here in the deposition today and try and elicit some opinion from her about topics which she has already testified she did not consider and has not considered and try to elicit what is the equivalent of opinion testimony from her is inappropriate. Obviously you can pursue the line of questioning, but just so that you know, our position will be that none of this is relevant, admissible or even appropriate.
MR. MANGI: You've made your objection. With respect I would ask that you limit your interruptions to making the objection rather than a speaking objection.

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Q. In any event, would you like the question read back?
A. Yeah.
Q. You may have forgotten it. Let me put it to you again. You've testified that you understood the reimbursement rate was 95 percent of AWP, right?
A. Yes, correct.
Q. You've testified that you thought the AWP was the natural average of wholesale prices, right?
A. Well, actually I thought it was a number. It was a pricing -- a price number.
Q. Okay. But what did you think that number represented was my earlier question?
MR. COCO: Objection, asked and answered.
Q. Right.
A. I think it was a number. I really didn't think about what -- how they got up -- I assume -- it was a number. I assumed there was a standard formula for a number. It was a number.

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Q. Are you aware that there is a standard formula and that AWP is generally 20, 25 or sometimes 30 percent above WAC or wholesale acquisition cost?
MR. COCO: Objection.
A. I don't know that.
Q. Let me ask you a simple question then: Is it your understanding that you thought AWP was a natural average of wholesale prices, or is it your position that you knew AWP was a number, but you weren't sure what, if anything, it represented?
MR. COCO: Objection.
A. I think that I thought it was the average wholesale -- I thought it was a number. I really honestly thought it was a number. I didn't give a lot of thought about -- I just didn't think about it a lot. It wasn't a big part of my business, and it's just -- it's a number.
Q. So would it be fair to say that you thought AWP was a number?
A. Yeah.

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Q. But beyond that you didn't know what, if anything, it represented?
MR. COCO: Objection.
Q. Would that be a fair statement?
A. I think it's fair to say that, yes.
Q. Now, are you aware that the plaintiffs in this litigation of which BC/BS is the named class representative have taken the position that payers such as BC/BS of Massachusetts have long known that AWP is not an actual of average wholesale prices?
MR. COCO: Objection.
A. Try that again -- can you say that again?
Q. Sure.
MR. MANGI: Would you mind reading the question back?
(Record read.)
MR. COCO: Objection.
A. Not said that way, no.
Q. Are you aware of the fact that the plaintiffs in this case have long -- have taken

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the position that it's been long known that acquisition prices for drugs and the actual average wholesale prices for drugs are different things?
MR. COCO: Objection.
A. I don't know what they've said.
Q. So let's go back to my initial question, which is, BC/BS of Massachusetts is a plaintiff in this case, you're the medical director -- one of the medical directors for BC/BS of Massachusetts and the chair of the P&T committee. What is your understanding as to what BC/BS of Massachusetts is alleging the defendants did wrong?
MR. COCO: Objection.
A. I have a very high level understanding of this in terms of the fact that there was -- that the price -- there's an issue with AWP pricing. I really don't know the details. I really haven't asked and it's not really connected with my daily business concerns.
Q. Okay. Now, your daily business concerns involve dealing with providers; is that correct?

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A. That's true.
Q. And those providers are reimbursed in relation to AWP; is that correct, the majority of them?
MR. COCO: Objection.
A. Not the majority. I mean, you mean -- if you're talking about physicians in offices --
Q. Right.
A. -- that you're administering like drugs in their offices, yes, that's my understanding.
Q. Now, leaving aside whatever positions plaintiffs have taken in this case --
A. Yeah.
Q. -- do you personally --
A. Yeah.
Q. -- have a view as to whether you have been misled by anything that drug manufacturers have done or not done in relation to AWP?
MR. COCO: Objection.
A. I don't know enough about it to say.
Q. Now, when I asked you originally what your understanding of the allegations was, you

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said one part of it is what AWP meant?
A. Yes.
Q. And you also said you understood it referred to pricing considerations. Now, what were you referring to when you used the term "pricing considerations"?
A. My -- you know, I said my level -- understanding is very high level. I understand that there was some issues around what AWP meant and what pricing or what monies the physicians were receiving -- or, you know, what -- basically that whole interaction about what the AWP is and what drugs are available at. I mean, that's the about the level of my understanding of this.
Q. Okay.
THE WITNESS: Can we take a break pretty soon?
MR. COCO: Sure.
THE WITNESS: I'm tired.
MR. MANGI: Sure. Let's take a break.
(Recess taken.)
MR. MANGI: Back on the record.

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Q. Now, before the break, Doctor, we were talking about the relationship between pricing which providers acquire drugs and the rate with which they're reimbursed by BC/BS of Massachusetts. Based on your experience in dealing with providers and fielding provider complaints, how do you think providers would react if they were being reimbursed below their acquisition costs for reimbursement?
MR. COCO: Objection.
A. How do I think they would react if they were -- personally I think that they probably wouldn't deliver those services, but not everybody does.
Q. So let's postulate a world in which doctors were being reimbursed at an average of their acquisition costs. As you mentioned earlier, in that situation some doctors below the average, above the average were being reimbursed below their cost, right?
MR. COCO: Objection.
A. I mean, I don't -- you know, I have -- I

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seriously have not thought about that. I have no idea what -- I would assume that people who -- if you -- just from a business perspective if your costs aren't being met, you wouldn't continue doing something, but, you know...
Q. So, in other words, from a standard business perspective, if doctors were being reimbursed below their cost for drugs by any payer, they would stop administering those drugs in their offices, right?
MR. COCO: Objection.
A. Not necessary -- I mean, they also get other -- they also get other fees, though. So I mean, they get a technical component, they get office visits, so I mean, you would have to understand the whole business proposition on, you know, what their -- you know, what they're getting paid for delivering a bunch of services.
Q. Let's talk about that issue for a moment now. Are you familiar with the term "cross-subsidization"?
MR. COCO: Objection.

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A. Yes.
Q. What is your understanding of that term?
A. I mean, from my personal understanding I would think that certain things -- it means that certain things subsidized -- paid for other things.
Q. Do you have an understanding as to how, if at all, that term has been used in relation to reimbursement to providers?
MR. COCO: Objection.
A. Broadly, no. I mean -- no.
Q. Now, BC/BS of Massachusetts traditionally until recently followed Medicare in terms of reimbursing for drugs at the same rate as Medicare, right?
A. Correct.
Q. Did BC/BS of Massachusetts also follow Medicare in terms of the rate it reimbursed for services?
MR. COCO: Objection.
A. Blue Cross/Blue Shield of Massachusetts tends to be Medicare-like in its reimbursement.

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And we don't necessarily follow Medicare rates, we follow a lot of them but not always their methodology for rate reimbursement.
Q. Okay. Well, Medicare determines the rates at which it would reimburse for services, incidental drug administration, and it's through the RBRES scheduling process, right?
A. Yeah.
Q. Did a Blue Cross/Blue Shield of Massachusetts apply the same process and pay at the same rate as Medicare for drugs administered in office?
MR. COCO: Objection.
A. You know, we don't necessarily pay the same rate as Medicare, but we usually follow the same -- we use the RVUs methodology in a lot of our reimbursement strategies.
Q. Okay. Do you know whether the amount at which Blue Cross/Blue Shield of Massachusetts reimburse providers in relation to services was more or less than the amount Medicare reimbursed in relation to the same services?

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A. I think that, you know, it varies and we're talking about a lot of services, and I think --
Q. Let's focus on services incident to drug administration.
A. I don't know what the reimbursement level is compared on that topic.
Q. Are you aware that providers and provider groups have argued for many years that the amount Medicare reimbursed in relation to services alone was insufficient to cover providers' costs?
MR. COCO: Objection.
A. Medicare reimburse -- could you state that last piece?
Q. Sure. Well, you deal with provider groups such as MASCO, don't you?
A. Yes.
Q. Are you aware that provider groups of that type and providers had long taken the position that the amount Medicare reimburses physicians in relation to services incident to

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drug administration is insufficient to cover those providers' costs?
MR. COCO: Objection.
A. It would -- I mean, whew, I think that I am aware that they had some concerns about the new methodology that Medicare had put in place. That, I was aware of because they called that to our attention, that they thought that that methodology was going to be evolving.
Q. Okay. I understand. My question's going to be a little bit different.
A. Okay.
Q. My question goes to the pre-ASP period.
A. Okay.
Q. In that period --
A. Yeah.
Q. -- are you aware that providers and provider groups took the position that the amounts being reimbursed for services alone were insufficient to cover costs?
MR. COCO: Objection.
Q. And just to be clear, my question is:

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Are you aware that they took that position?
MR. COCO: Objection.
A. Not quite the way you're saying it. I will say in general that I think that most providers think that Medicare is not a generous payer, and that I am aware of. And that most people think that it isn't the most generous of payment payer, so that I can say that fairly.
Q. Have you ever heard of providers, provider groups or anyone else making the argument, making the point that the amount reimbursed by Medicare in relation to drugs administered in office acts as a subsidy to help cover the physician's costs of administering the drugs?
MR. COCO: Objection.
A. I can't recall anybody specifically ever saying it quite like that, or saying that in general. I'm trying to think of if I ever heard anybody say it like that. I can't recall.
Q. Well, let me ask you this: You're aware that Medicare has now moved to an ASP plus six

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methodology; is that correct?
A. Yes, I am aware of that.
Q. And ASP is intended to more closely approximate the average of actual acquisition costs for physicians, right?
MR. COCO: Objection.
A. Can you say that again?
Q. Sure. Well, let me ask it another way.
A. Yeah.
Q. Do you know what ASP is?
A. I heard average sale price.
Q. And what is your understanding as to what average sale price means?
A. Average sale price. Okay, I mean --
Q. Beyond what the acronym stands for, do you have an understanding as to what that means in the marketplace?
A. No, I don't.
Q. Do you have an understanding as to whether or not average sales price numbers are higher or lower than AWP?
MR. COCO: Objection.

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A. You know, I don't think I know for sure, no.
Q. Are you aware that when Medicare moved to an ASP-based methodology, it made upward revisions in the amounts it was being reimbursed in relation to services incident to drug administration?
A. You mean, the technical component? Is that what you're asking?
Q. What do you mean by "technical component"?
A. That's what I'm trying to think, is that what you mean. It's the administration fee is that what you're saying like for the fee for administering a drug itself? Is that what you're asking me?
Q. Well, let's focus the query. When physicians bill in relation to drugs that they administer in office they use pixfix (phonetic) codes, right?
A. Okay.
Q. Are you familiar with pixfix codes?

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A. I would say J codes.
Q. That's fine.
A. Okay.
Q. And you aware that there are some J codes that pertain to drugs?
A. Yes.
Q. And there are some J codes that pertain to services?
A. There is a service code like for administration of a drug.
Q. Sure.
A. Okay.
Q. Now, those service codes pertain to services that the physician provides that are related to an incident to the drug administration?
A. Right.
Q. Which may involve the infusion or injection or other related services?
A. Right. It's related to the administration of the drug, right?
Q. Okay. So that's what I'm referring to when I say "services incident to drug

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administration."
A. Okay.
Q. Now, using that definition, are you aware that when Medicare moved to an ASP-based methodology, it substantially revised the amounts of the reimbursed buyers in relation to services incident to drug administration?
MR. COCO: Objection.
A. I know that they were looking at revising that, and I heard -- I don't know if they actually revised it. I know that they were doing cost studies related to that. I was told that by the provider groups and that they also did like a -- I want to say a demonstration fee. I don't know if that's exactly what it was called, but the idea was that there was an amount of money that was given while -- the period while the costs were being -- there was some question about what how much it cost to administer the drug in the office and things like that.
Q. The demonstration project is a separate issue, and I will come to that later.

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A. Okay.
Q. But sticking with the services incident to drug administration, are you aware that based on Blue Cross/Blue Shield of Massachusetts's own analysis some service fees were increased by Medicare by almost 400 percent?
A. I wasn't --
MR. COCO: Objection.
A. I wasn't aware of that.
Q. Has the upward revision in administration fees by Medicare attendant to the move to ASP something -- is that something that providers have raised with you in relation to discussing BC/BS of Massachusetts reimbursements?
A. Not recently. I mean, they haven't -- I mean, in terms of are we increasing the reimbursements or is Medicare?
Q. Have they raised them in any context?
A. The only context that I really had the discussions with was MASCO in terms of what they were doing with Medicare on that piece. I haven't had other providers talk to me about it.

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Q. What discussion did you have with Medicare on that issue?
A. Excuse me --
MR. COCO: MASCO.
Q. With MASCO, I apologize.
A. MASCO. Simply that they were saying that the methodology was changing. They were concerned about the methodology that was being changed, that they wanted to -- they thought that what Medicare was doing was a changing thing because I think they thought that the original proposal was not adequate, that cost studies were being done to look at the actual costs in the office, and in the meantime that they were receiving a fee or a demonstration project fee for what they were doing.
Q. And were your communications with MASCO on this topic in connection with BC/BS of Massachusetts's consideration as to whether or not to move to an ASP-based methodology?
MR. COCO: Objection.
A. No, it was in conjunction -- they wanted

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to know what we were going to do. They were concerned because a lot of times we are very Medicare-like and we had been following Medicare-like reimbursement methodology, and they wanted to engage us to see what were we going to do.

Q. Now, what time frame was this in?

A. That, you know, I didn't look at -- I can't remember when those -- it's been in the last several years. I can't tell you how -- I can't tell you how far back that went, but it's not been -- you know, it's been since I've been in my current position, and it's been a couple years that I was in that current position that we started talking about these.

Q. Now, you're aware that Blue Cross/Blue Shield of Massachusetts did not move to any based methodology and currents to reimburse amount AWP minus 5 percent?

A. Yes, I am aware of that.

Q. What is your understanding as to your reasons why -- well, withdraw that.

Up until recently Blue Cross/Blue Shield

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of Massachusetts always reimbursed -- always followed Medicare in terms of setting its reimbursement rates for drugs administered in office, right?

MR. COCO: Objection.

A. Well, not always but we were following a Medicare-like thing, yes.

Q. Well, you were always reimbursing at the same percentage of AWP as Medicare, right, throughout the 1990s?

A. That, I don't know.

Q. Okay. It's your understanding that the reimbursement rate was somehow tied or connected to the Medicare reimbursement rate in relation to drugs?

A. Not -- no. My understanding was like a lot of our payment policies, we are Medicare- like because they're one of the largest payers; we do things like them. So their pricing in the 2000s was like what Medicare was doing. That methodology was alike.

Q. Are you aware that other Blue Cross/Blue

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Shield of Massachusetts witnesses have testified that right up until Medicare moved up to ASP Blue Cross/Blue Shield of Massachusetts always followed Medicare precisely in terms of its reimbursement methodology for drugs administered in office?

A. I'm not --

MR. COCO: Objection.

A. I'm not aware of what they said.

Q. Do you have any reason to think that's incorrect?

MR. COCO: Objection.

A. I don't know one way or the other.

Q. Now, you do understand that Blue Cross/Blue Shield of Massachusetts considered whether or not to move to ASP in the 2004 time period; is that correct?

A. I think that my understanding is that we had discussions about what Medicare had done. I was involved in some discussions.

Q. Okay. Are you aware that Blue Cross/Blue Shield of Massachusetts analyzed the financial implications attendant on a move to ASP?

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A. I may be -- I'm trying to think it's been a while. I was sure -- I think that probably something was done to look at that.

Q. Are you aware that Blue Cross/Blue Shield of Massachusetts concluded in 2004 that it could save approximately $6 million a year if it did move to an ASP-based methodology, even accounting for an increase in administration fees?

MR. COCO: Objection.

A. I'm not aware of that number, but I think I'm aware that they thought there was a cost saving, but I don't know if that's the right number.

Q. But you're aware that Blue Cross/Blue Shield of Massachusetts decided nonetheless not to make the shift?

A. At that -- what I am aware of is at that time that they didn't decide to make the shift, no, at that time.

Q. And since that time has a different decision been made on that topic?

A. What I'm aware of is that I'm assuming

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that at some point in time we will make that shift when things are more -- you know, I'm peripheral to a certain extent to these discussions, but my knowledge stems from the fact that people tell me things to tell providers like MASCO and that one of the things that, you know, when we get more information about the cost studies, when we are sure that Medicare is not going to change their methodology again, we have other kinds of pricing in place, then I think that we would entertain that again.

Q. But to date certainly there's been no decision to move away from the current methodology; correct?

A. There's been no decision on a timeframe to move away, but I would say that I think people are expecting that we will move away from the methodology.

Q. Now, what were the reasons why Blue Cross/ Blue Shield of Massachusetts did not move to an ASP methodology when the issue was first considered in 2004?

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MR. COCO: Objection.

A. You know, I don't know why the company didn't, but from the piece that I know I think -- I relate back that there was some concerns from a provider group like MASCO that they thought that the methodology -- the Medicare methodology, was not -- may continue to evolve. They were concerned about how things were being set because they didn't think that price -- the actual costs of the office were known well. And I think they also, at that point in time, were talking quite vocally, internally and externally, about how they were going to be treating Medicare patients and whether they were going to continue to take care of them in their offices.

Q. Now, would it be fair to say that the concern that groups such as MASCO providers were voicing partly through you directly was that the amount that they would be reimbursed under an ASP regime would be insufficient in their eyes?

MR. COCO: Objection.

A. I think they were just concerned about

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the whole methodology. I mean, I'm not sure if it was the ASP or it was the technical component or whatever. They were concerned that the methodology was not sufficient for them to continue their operations.

Q. In other words, they took the position that after Medicare's shift in its methodology and all of the aspects of that shift, they would not be making a sufficient amount of money to enable them to continue treating Medicare patients --

MR. COCO: Objection.

Q. -- is that correct?

A. I think that the position they took about -- I don't know if it was a sufficient amount of money they would be making, but I don't think that they thought -- they were concerned would they be able to continue to offer -- to afford to offer those services in their office.

Q. Okay. And whether or not they would be able to afford it --

A. Yeah.

Q. -- would be a function of what this

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differential was between their costs and their reimbursement, right?

MR. COCO: Objection.

A. I think that they related something to that effect.

Q. Okay. And the concern was that with the shift they might stop treating Medicare patients because the reimbursement terms did not meet with their approval; is that correct?

MR. COCO: Objection.

A. I think that that's what they conveyed to us and they conveyed to a lot of people.

Q. And they also conveyed to you that if Blue Cross/Blue Shield of Massachusetts made a similar shift in methodology, they may stop treating Blue Cross/Blue Shield of Massachusetts patients for the same reasons --

MR. COCO: Objection.

Q. -- is that correct?

A. I don't know if they ever quite came out and said it, but certainly --

Q. That was the implication?

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A. I think the implication was that they were saying they thought the methodology was evolving. They weren't sure that they were going to be able to continue to do this in the offices, that if -- that, you know, if we adopted that methodology, that they had concerns about it, the way it was -- methodology was stated at that time.
Q. The implication was that with the -- if Blue Cross/Blue Shield of Massachusetts were to make a shift similar to what Medicare was contemplating, they would no longer be able to participate in the network; is that a fair statement?
MR. COCO: Objection.
A. They never went that far, okay? It never was -- I don't think it was ever that explicitly said.
Q. Was that the implication?
MR. COCO: Objection.
A. I think my opinion was that they were gravely concerned about what was happening to their reimbursement levels and they wanted to

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express that concern to us. Whether or not what they would have done, I don't know if they would have really done it, but -- what they succeeded in saying was that they were concerned, and they were -- you know, they were very concerned and they wanted to engage us in talking about what we were going to be doing.
Q. Now, why did that matter to Blue Cross/Blue Shield of Massachusetts?
MR. COCO: Objection.
A. Well, I can't talk about -- I can only talk about Blue Cross/Blue Shield of Massachusetts in terms of I'm one of their associates, and why it matters to me is that we tried to work collaboratively with the providers, both facility and clinical providers in our networks because we believe that leads to the best healthcare delivery for our members. So we have sort of a collaborative -- we try not to be adversarial. We try to be respectful and collaborative when we engage with our providers.
Q. And part of the reason why maintaining

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those good relations is important is because Blue Cross/Blue Shield of Massachusetts needs a network of physicians to provide treatment to its members, right?
MR. COCO: Objection.
A. Well, not really because we would have it anyway because pretty much, you know, we're a very large payer and I think people -- I think we do it more because we think that together we can achieve more. We're very community-minded. I think we think that we can achieve better delivery systems if we're all working together. So I don't think it ever comes down to they're many payers who are not very collaborative with their providers, but people still take their money.
What we're looking for is a higher level of -- we're trying to deliver a better product, so we're looking for innovation. We're looking for better health outcomes. We're looking for better delivery systems.
Q. So what you're saying is, if I understand you correctly, it's not just a matter

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of paying enough so that physicians will remain in the network. Blue Cross/Blue Shield of Massachusetts wants to go beyond that; is that correct?
MR. COCO: Objection.
A. We want to -- no. It's the payment -- payment has to be affordable. Things have to be affordable for our membership. What I'm saying to you, I guess, is the spirit. In terms of we like to have a collaborative spirit and we like to work versus being in a collaborative relationship versus an adversarial, and we don't always say yes to people. In fact, most of the time we don't. It's more of the fact of listening and being respectful. And listening, that's really important.
Q. Right. And part of that relationship or that ethic when it came to these issues and whether or not to shift to ASP was that you wanted to give a full and a fair hearing to what the providers' concerns were; is that a fair statement?

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MR. COCO: Objection.
A. We wanted to -- we wanted to listen to what they had to say and we wanted to validate to them that we valued them and their participation and their taking care of our members.
Q. It's fair to say, isn't it, that the providers' concern around this shift was not just specific to the ASP part or the technical part or the demonstration part, their concern was related to the overall reimbursement they would be receiving under the new medication regime?
MR. COCO: Objection.
Q. Is that a fair statement?
A. I don't know if it was that broad. I mean, I don't know what -- how far or how deep their concern was in that regard.
Q. Well, my -- perhaps my question wasn't clear. As I understood your earlier testimony, the providers' concern was not how the number is calculated, in other words, whether it's ASP plus something or AWP minus something, their concern was that with the shift in Medicare's

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reimbursement methodologies, the dollar sums that they would be reimbursed would be insufficient to enable them to continue doing what they had been doing?
MR. COCO: Objection.
A. I'm not so sure that it was insufficient as less.
Q. Okay. Well, let me put it that way then: So their concern -- withdraw that.
So the providers and MASCO's concern around the time when Medicare was contemplating a shift in methodology was not, you know, what is the methodology or what is the benchmark or what are the different components of it. The concern came down to the fact that the dollar sum they would be getting at the end of the day was less than what they had been getting before?
MR. COCO: Objection.
Q. Is that a fair statement?
A. You know, I can't say what -- I can only say what they expressed to me.
Q. Sure.

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A. And I think what they expressed to me was that was what they were concerned about, okay?
Q. That's fine. I'm not trying to, you know, pose a trick question.
A. Yeah.
Q. So you understood -- let me phrase it that way so we're clear.
The concern that you understood they were expressing to you was that with the shift in methodology that Medicare was implementing from an AWP-base system to an ASP-based system, the overall amount of reimbursement they would receive in dollar terms would be less than what they were getting before, right?
MR. COCO: Objection.
A. I think -- and I want to broaden that. I think the whole change in methodology, and it's not unusual, but whenever significantly changing a methodology for reimbursement it's not unusual for people will be concerned, am I getting less? I don't think if they thought they would be getting a lot more they would have been as concerned but

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of course they want to ensure that they are getting enough -- they want to ensure that they were getting what they were getting before, or they were worried that they would be getting less.
Q. And that concern is one of the factors that BC/BS of Massachusetts would have considered in making its decision not to follow Medicare in moving to an ASP-based methodology, correct?
MR. COCO: Objection.
A. I think that we listen, but we wouldn't have done that solely because they -- you know, I think we listen to them, but I don't think that that's what I -- we didn't make that shift in that methodology.
Q. My question is: Was that one of the factors that BC/BS of Massachusetts would have considered in making its decision not to shift methodologies?
MR. COCO: Objection.
A. I would have considered it, but I don't know -- I wasn't part of the decision making body on that, so I don't know if they considered it or

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not.
Q. Are you aware that previous BC/BS of Massachusetts witnesses have testified that you were part of the group that was analyzing whether or not to move to an ASP?
A. No, I'm not aware that they said that.
Q. Would that be inaccurate?
A. It's inaccurate in the sum that you said there was a committee or a group that was looking at it. I think specifically that was like the call to the committee. You know --
Q. Well, let's not make it that formal then.
A. Okay.
Q. Forget about a committee or a group.
A. Yeah.
Q. My question is: There were people that were looking at this issue and their input factored into the eventual decision. Were you one of those people?
A. I was involved in conversations about this topic.

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Q. Okay.
A. I'm not sure who eventually made the decision, but I don't remember sitting around a table and everybody said raise your hand in you're in favor -- I wasn't -- that wasn't in that level. I certainly was involved in talking about what I had learned and what I thought about this topic.
Q. And is one of the things that you conveyed about this topic the concerns we've discussed from MASCO and providers that they would be making less?
MR. COCO: Objection.
A. What I conveyed is what we had heard in our discussions with MASCO.
Q. Okay. Now, after taking those considerations into account, Blue Cross/Blue Shield of Massachusetts decided not to shift methodologies, right?
MR. COCO: Objection.
A. I don't know if that -- I don't know if that was the reason, and I don't think that was the reason they decided not to shift.

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Q. But had -- I'm sorry go ahead?
A. I don't think that was the sole reason or maybe even the main reason watch. Do I think that people heard that? Yes, I think that people heard that.
Q. My question was: Was it one of the factors that was provided to the group for consideration?
MR. COCO: Objection.
A. I talked about that to people that have been in involved in the decision making but since I don't really know who exactly made the decision. I can't really tell you that was the case, okay?
Q. Do you know what other factors that may have gone into that? Were there other factors that were discussed?
MR. COCO: Objection.
A. In the discussions that I had, one of the things that was discussed was that other kinds of pricing that we had, because you're talking about -- there are a lot of different places that those types of drugs can be given. You know,

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they're infusions is what we're talking about for the most part, but not always. And infusions can be given in the hospital, they can be given in the outpatient department of hospitals, they can be given in physicians' offices, they can be given in home settings. And those, I think, are the big ones that I can think of off the top of my head.
And one of the things that we talked about is the different pricing in the different areas of the company in regards to where those drugs could be given. And that was one of the things that was discussed.
Q. Well, how is the presence of alternative sites of care relevant to the decision of whether or not to shift methodologies?
MR. COCO: Objection.
A. From my perspective it could be relevant if you were thinking about alternative sites -- well, I mean, those are all -- those are four sites I told you where care could be delivered and not all types of drugs would be delivered in those sites. But, you know, if you were looking at

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places where things could be alternatively delivered, let's say if there was a shift of care, if care wasn't going to be delivered in one but maybe we delivered in another site, well, what would -- that was what the discussion was about.

Q. Do you have an understanding as to whether or not it costs Blue Cross/Blue Shield of Massachusetts more if a drug is administered to a patient in a hospital versus a physician's office?

A. Well, if it's delivered during a hospital stay, for the majority of the time most of that's under the DRG payments, that is different. But you mean like an outpatient --

Q. (No verbal response.)

A. Okay. It was a different pricing methodology. It wasn't -- from the most part and I'm just being very general now. My understanding was that in most of the hospital contracts, or a lot of them they're all very different, that the pricing wasn't AWP minus 5 percent in the outpatient setting, and a lot of those it was percent of charges.

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Q. Well, my question is a bit broader than that: In terms of the overall reimbursement related to a drug administration or to drug component and the service component, as a general matter, would it cost Blue Cross/ Blue Shield of Massachusetts more or less if a drug was administered in a hospital outpatient department versus a physician's office?

MR. COCO: Objection.

A. I would say that -- I don't have -- I've never seen numbers that would support that. I think -- what I think and what I thought is that it's probably more expensive to give something in a hospital setting just in general than it would be in other settings.

Q. Do you know whether or not that general fact played any role in Blue Cross/Blue Shield of Massachusetts's determinations of the amounts reimbursed in physician office settings?

MR. COCO: Objection.

A. Can you clarify what you mean by that?

Q. Well, let me put it another way: Do you

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know whether or not Blue Cross/Blue Shield of Massachusetts, in dealing with particular physicians, considers or is concerned about the fact that if a provider stops treating their patients for any reason, those patients will then go to a hospital outpatient department to get their drug and it'll cost Blue Cross/Blue Shield of Massachusetts more?

MR. COCO: Objection.

A. I don't think we think about that in terms of individual physicians. I mean, I don't think you would look at it quite that way, but I do think that we think that usually any kind of services delivered in a hospital versus, you know, in a doctor's office tend to be more expensive.

Q. We can agree as a general matter it's in Blue Cross/Blue Shield of Massachusetts's interest that patients be -- receive their drugs in a physician office setting versus in a hospital setting, both for financial reasons and also for the patient's own comfort?

MR. COCO: Objection.

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A. Actually, I disagree with that. I would tell you I think that my understanding as an associate of the company, as a physician I would hope people would receive the drug in the most clinically appropriate place and not, you know, all medications are alike and equal, and some of them are more dangerous than others, and some of them are more safe. And, you know, we talked about outpatient. We talked about, you know, home, et cetera. So the most safe -- the best place for the patient is where I would hope somebody would receive a medication.

Q. Let's assume that we're talking about drugs where is the patient's clinical interests are equally serviced, whether they would be getting the drug in a hospital outpatient department or in a physician office setting. I'll ask you to assume that for purposes of this question.

A. Okay.

Q. All right. In that setting with that assumption can we agree that it's in Blue

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Cross/Blue Shield of Massachusetts's interests financially that the patient receive the care in the physician's office setting rather than the hospital outpatient's setting?

MR. COCO: Objection.

A. I don't know about that. I mean, I don't mean to be vague with you but I'm not so sure about that. I think that -- I look at that more as a patient -- a place of patient preferences and I have not seen the cost studies between the two of them, between the outpatient setting -- I told you a generalization of something I believe that a hospital -- and a physician's office but there's more than just cost.

There's also quality concerns, so, you know, I would tell you that I think my understanding of this issue is that we would -- that as a company we would hope the people would receive it in the safest place that they would receive it and sometimes for people the safest place or the place they feel more comfortable is

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in a physician's office. But, you know, I mean, I think that's -- we didn't think about this a whole lot. We really weren't thinking about this a whole lot.

Q. Okay. What do you mean when you say you weren't thinking about this a whole lot?

A. I mean, you're asking me a lot of questions in terms of -- I don't think this is really high on -- in my personal perspective on the radar screen about, you know, people actively directing. I'm not aware that we were directing people to certain sites of service or really even -- we just, you know, we weren't really -- I'm not aware that we did that kind of thing or we were thinking about that kind of thing or I certainly wasn't thinking about that kind of thing.

Q. So are you saying you're not aware of any efforts to incentivize any site of care versus another one?

MR. COCO: Objection.

A. No. I guess what I'm saying is that I'm not aware that -- I'm just not thinking this was

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something that people were spending a lot of time thinking about.

Q. My question was a little bit different.

A. Yeah.

Q. My question was: Are you saying you're not aware of any efforts by Blue Cross/Blue Shield of Massachusetts to incentivize one site of care versus another?

MR. COCO: Objection.

A. Well, "incentivized" is kind of a broad, you know, vague term, but I'm not aware that we were actively directing care one way or the other. And that's how I can answer that, and that's what I meant by that.

MR. COCO: When you get to a good breaking point, it might be --

MR. MANGI: Lunch? Yeah, let's do it now.

MR. COCO: Okay.

(Lunch recess taken.)

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AFTERNOON SESSION

MR. NOTARGIACOMO: Before we begin, I just wanted to designate the transcript as confidential under the applicable protective order that's been placed in this litigation.

(JAN L. COOK, M.D., Resumed.)

DIRECT EXAMINATION, Continued

BY MR. MANGI:

Q. Now, Dr. Cook, in the morning session you mentioned at one point the transformation initiative that Dr. Mandel, I believe, is working on. What is the transformation initiative?

A. The transformation initiative, in 25 words or less, okay, it's actually a corporate initiative to try to improve the health and well-being of the citizens of Massachusetts. That's sort of the lofty high goal. And the idea is, you know, what can we do as a company to try to stimulate, you know, safer, higher quality, more affordable healthcare in Massachusetts. And so